AIDS/HIV HEALTH INSURANCE PREMIUM SUBSIDY PROGRAM AND DRUG ASSISTANCE PROGRAM

APPLICATION PART A – APPLICANT

Before completing this application read separate fact sheet and Application Instructions

Check the program (s) for which you are applying: ☐ Health Insurance Premium Subsidy Program ☐ Drug Assistance Program

SECTION I. GENERAL INFORMATION

Last Name	First Name	Middle Initial	Date of Birth

Social Security Number (Disclosure of your Social Security number (SSN) is voluntary, however most insurers and pharmacies use the SSN to identify policies and records. Supplying your SSN will expedite verification of insurance coverage and the processing of this application.) ☐☐☐ - ☐☐ - ☐☐☐☐

If mailing address is different than street address give both addresses.

Street Address (House number, street name)				Mailing Address			
City	County	State	Zip	City	County	State	Zip

Home Telephone Number (Include area code) _____

Is it all right to leave a message at this number? ☐ Yes ☐ No

Work Telephone Number (Include area code) _____

Is it all right to contact you at work? ☐ Yes ☐ No

Gender	Marital Status	Veterans Status	Race	Ethnicity
☐ Male ☐ Female ☐ Transgender	☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living with a Partner	☐ Veteran ☐ Not a Veteran	☐ Caucasian (White) ☐ African American (Black) ☐ Asian ☐ Pacific Islander/Hawaiian Native ☐ Native American/Alaskan Native ☐ Other_____	☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a

Residency (Check which best describes your current residency) ☐ Resident of Wisconsin ☐ Not a resident of Wisconsin

Name of Case Manager	Agency Name and Telephone Number

Employment Status (Check which best describes your current employment status)

☐ Employed Full-time ☐ Temporary Medical Disability Leave ☐ Not Employed Due to Illness
☐ Employed Part-time ☐ Reduced Work Hours Due to Illness ☐ Not Employed/Non-Medical Reason

Physician Information		Pharmacy Information	
Physician Name		Pharmacy Name	
Clinic Name		Contact Person	
Street Address		Street Address	
City		City	
State	Zip Code	State	Zip Code
Telephone Number (Include area code)		Telephone Number (Include area code)	Fax Telephone Number (include area code)

SECTION II. FINANCIAL INFORMATION

Use the space below to list all sources of income and the amount of monthly gross income from each source. You must attach proof of the income listed below. Attach a copy of the most recent benefits or paycheck stub(s), or a copy of your latest tax return or W-2 form, whichever most accurately provides proof of your current income, or a copy of your social security disability determination letter. Failure to include proof of income will delay or prevent your enrollment in these program(s).

Source (Monthly)	Self	Spouse	Total
Gross wages and salary			
Social Security Disability Income (SSDI)			
Social Security Supplemental Income (SSI)			
Dividends and interest			
Estate/trust income, net rental income, and/or royalties			
Public assistance			
Pensions, annuities, and/or veteran's pension			
Unemployment and/or worker's compensation			
Child/family support/alimony			
TOTAL OF ALL SOURCES			
FAMILY SIZE – Include yourself, spouse and/or legal dependents			

If you have no income, you must indicate how you are supported (i.e., relatives, friends). Failure to include this information may delay the application process_____

SECTION III. INSURANCE COVERAGE INFORMATION

Check all boxes that describe your health insurance status.

- ☐ No health insurance of any kind
- ☐ Medicaid coverage (Title 19, MA). If you have a Medicaid spendown, what is the amount? $_____Date_____
- ☐ Medicare coverage
- ☐ Wisconsin Health Insurance Risk Sharing Plan (HIRSP) Major Medical Policy.
- ☐ HIRSP Medicare supplement insurance
- ☐ Medicare supplement insurance other than HIRSP
- ☐ An individual insurance policy other than HIRSP
- ☐ A group insurance policy provided by an employer
- ☐ COBRA or similar continuation coverage
- ☐ Dental insurance or coverage for routine dental care through my health insurance
- ☐ Other_____

Insurance Policy Information (If you have health insurance, please fill out the following sections. Most of this information can be found on your insurance card.

Policy Number	Policy Begin Date	Policy End Date

Insurance Company Information

Name of Insurance Company	Customer Service Phone Number
Insurance Company Address	City
State	Zip Code

Prescription Drug Coverage

Does this policy cover prescription drugs?	☐ Yes ☐ No	What is your dollar amount for copay per prescription?	$
What is your annual drug deductible?	$	What is your percentage of copay per prescription?	%
Does your policy have a maximum annual out-of-pocket contribution from you for drugs? If so, how much?			$

Employer/Group Information

Employer/Group Name	Employer/Group Number		
Street Address	City	State	Zip

Policyholder Information (If different than self)

Name (Last, First, MI)

Street Address	City	State	Zip
Telephone Number	Social Security Number (Optional)		

Premium Payment Information

If applying for the insurance subsidy program complete the following information about how your insurance premium is paid . (Premiums are usually paid directly to the insurance company or to the former employer)

Name of Individual or department the premium check be made out to:

Address where premium should be sent

Name and Telephone number of contact person receiving premium check

Regular Premium amount $	Next Payment due	Regular due date	Premium is paid ☐ Monthly ☐ Quarterly

If you need to make a payment that is different from the above information, please explain. Be specific about what is due and why, include the exact amount and due date:

NOTE: For Health Insurance Premium Subsidy Program only, if your income is between 201-300% of the federal poverty level, you will be required to make a 3% contribution toward the payment of your annual subsidy premium. The annual policy premium is determined by annualizing the first monthly premium that is due for the benefit year. If applicable, information about your expected premium contribution will be forwarded to you in your approval letter.

IMPORTANT: If you are on a COBRA (or similar) extension, please include a copy of the letter from your former employer explaining your extension benefits.

OR

If you are regularly billed for your insurance, please send us a copy of your insurance bill.

AIDS/HIV HEALTH INSURANCE PREMIUM SUBSIDY AND DRUG ASSISTANCE PROGRAMS AUTHORIZATION TO RELEASE INFORMATION

I authorize the Wisconsin Department of Health and Family Services (DHFS) to receive and disclose medical information related to my HIV status to DHFS staff, my designated pharmacy, my physician, my case manager, my insurance company and/or my employer as needed to determine my eligibility for benefits under either the Wisconsin AIDS/HIV Health Insurance Premium Subsidy or the Drug Assistance Programs and to administer these programs.

I hereby certify that all the information I have provided in this application is true and complete. I understand that I am subject to losing my enrollment eligibility and possible prosecution under state and federal laws if this information is false.

SIGNATURE - Applicant or Guardian Date Signed

Print Name of Applicant or Guardian

Return the completed application
And income verification in an envelope
Marked **"CONFIDENTIAL"** to:

Division of Public Health
Attn: Health Insurance Premium Subsidy and Drug Assistance Programs
P.O. Box 2659
Madison, WI 53701-2659

Or fax to (608) 266-1288

DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 4614B (Rev. 07/04)

STATE OF WISCONSIN
AIDS/HIV Program
1-800-991-5532

AIDS/HIV DRUG INSURANCE PREMIUM SUBSIDY PROGRAM AND DRUG ASSISTANCE PROGRAM APPLICATION PART B – PHYSICIAN PORTION

The AIDS/HIV Program will maintain all information on this form confidential.

APPLICANT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth

Street Address

City	State	Zip Code	

HIV SERUM ANTIBODY TESTS

EIA Results	☐ Positive ☐ Negative	Test Date	WB results	☐ Positive ☐ Negative	Test Date
Most recent CD4 count		Test Date	Most recent viral load		Test Date
If diagnosed with AIDS give date of diagnosis					

EMPLOYMENT STATUS

Since initial diagnosis has this patient had to reduce work hours because of illness or medical condition arising from or related to the individual's HIV infection? ☐ Yes ☐ No

Is this patient on a medical leave because of an illness or medical condition arising from or related to the individual's HIV infection? ☐ Yes ☐ No

Has this patient terminated work because of an illness or medical condition arising from or related to the individual's HIV infection? ☐ Yes ☐ No

PHYSICIAN INFORMATION

Name (Print or type)	Telephone Number (Include area code)

Street Address

City	State	Zip Code

SIGNATURE – Physician	Date Signed

Return completed Part B of the application in an envelope marked **"CONFIDENTIAL"** to:

Division of Public Health
Attn: Health Insurance Premium Subsidy and Drug Assistance Programs
P.O. Box 2659
Madison, WI 53701-2659

Or fax to (608) 266-1288